Department of Defense
Pharmacoeconomic Center

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MCCS-GPE **7 Feb 2001**

MEMORANDUM FOR: Executive Director, TRICARE Management Activity (TMA)

SUBJECT: Minutes of the Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Executive Council Meeting

1. The DoD P&T Executive Council convened at 0800 hours on 7 Feb 2001, at Ft Sam Houston, TX. The DoD P&T Executive Council is responsible for performing certain inherently governmental functions relevant to the DoD pharmacy benefits program. The Council focuses primarily on issues related to the Basic Core Formulary (BCF), national pharmaceutical contracts, and blanket purchase agreements. The DoD P&T Executive Council is comprised of federal employees who are members of the DoD P&T Committee.

2. **MEMBERS PRESENT:**

CDR Terrance Egland, MC	P& T Committee Co-chair
COL Daniel D. Remund, MS	P& T Committee Co-chair
COL Mark Nadeau, MC	Air Force (alternate)
COL (select) John R. Downs, MC	Air Force
MAJ George Jones, BSC	Air Force
CDR Matt Nutaitis, MC	Navy
MAJ Brett Kelly, MS	Army
CDR Robert Rist	Coast Guard
Ronald L. Mosier	Department of Veterans Affairs
LtCol Steven Humburg, MC	Health Affairs
MAJ Mickey Bellemin, BSC	Defense Supply Center Philadelphia

MEMBERS ABSENT:

COL Rosa Stith, MC	Army
LTC Judith O'Connor, MC	Army
CDR Kevin Cook, MSC	Navy
Joint Readiness Clinical Advisory Board Representative	

OTHERS PRESENT:

COL William Davies, MC	DoD Pharmacy Program Director, TMA
COL Mike Heath, MS	Army Pharmacy Consultant; Chair, DoD Pharmacy Board of Directors
CAPT Joe Torkildson, MC	DoD Pharmacoeconomic Center
CAPT Pat Welter	Navy Bureau of Medicine & Surgery
CDR Mark Brouker, MSC	DoD Pharmacoeconomic Center
LTC Don De Groff, MS	DoD Pharmacoeconomic Center
LtCol Ed Zastawny, BSC	DoD Pharmacoeconomic Center
LCDR Ted Briski	TRICARE Region 9 Lead Agent Office
MAJ Cheryl Filby, MS	Defense Supply Center Philadelphia
MAJ Barbara Roach, MC	DoD Pharmacoeconomic Center
Capt Krissa Crawford, BSC	Pharmacy Practice Resident, Wilford Hall Medical Center
HM3 Cory Beckner	DoD Pharmacoeconomic Center
Angela Allerman	DoD Pharmacoeconomic Center
Shana Trice	DoD Pharmacoeconomic Center
Paul Vasquez	Defense Supply Center Philadelphia
Dana Dallas	Defense Supply Center Philadelphia

3. REVIEW MINUTES OF LAST MEETING

The minutes were approved as written.

4. ADVANCES IN MEDICAL PRACTICE (AMP) PROGRAM

Large budget shortfalls in the Defense Health Program jeopardize funding of the AMP program for FY 01. All AMP funds are currently "on hold" at TMA. Pharmacy will probably receive about $50 million if and when AMP funds are released. MTF pharmacies spent $12.1 million on AMP drugs in the first quarter of FY 01 (based on prime vendor data). Since expenditures for pharmaceuticals typically occur at the lowest rate during the first quarter of the fiscal year, total expenditures for AMP drugs will likely exceed $50 million in FY 01.

The Council considered a request from an MTF to add fluorodeoxyglucose (a radioactive fluoride used in positron emission tomography and single photon emission tomography) to the list of drugs covered by the AMP program. The Council denied the request because MTF expenditures for drugs currently covered by the AMP program will likely exceed the funds available for pharmacy in the AMP program.

5. NATIONAL PHARMACEUTICAL CONTRACTS

A. *Contract awards and renewals* – A joint VA/DoD single-source contract for clotrimazole 1% topical cream was awarded to Taro Pharmaceuticals with an effective date of 1 Feb 01. The joint VA/DoD single-source contract for acetaminophen 325 mg and 500 mg tablets announced at the last meeting became effective 1 Jan 01. MAJ Filby reported that the joint VA/DoD returned goods contract was awarded on 21 Jan 01 to Guaranteed Returns. LTC De Groff noted that 32 joint VA/DoD national contracts have been awarded, and approximately 25 more contracts are in various stages of development.

Information on national pharmaceutical contracts is available on the DSCP website (www.dmmonline.com).

B. *Financial impact of contracts* – COL Remund reported that the final estimate of MTF cost avoidance due to national pharmaceutical contracts was $65.2 million in FY 00, which equals 6.3% of the $1.03 billion that MTFs spent on pharmaceuticals. The weighted average percent reduction in cost for the drugs and drug classes affected by national pharmaceutical contracts was 25.3%. A summary of cost avoidance from national pharmaceutical contracts is provided in Appendix A.

C. *Status of solicitation for non-sedating antihistamine (NSA) contract* – The General Accounting Office (GAO) recently denied the only remaining protest of the solicitation for a joint VA/DoD "closed class" contract for a non-sedating antihistamine. The GAO denial of the protest opens the way for a contract to be awarded by the VA National Acquisition Center (NAC).

D. *Status of solicitation for oral contraceptive contracts* – The solicitation for joint VA/DoD single source contracts for four oral contraceptive products is scheduled to close on 23 Feb 01. The solicitation is for single sources of the following oral contraceptive products: 35 mcg ethinyl estradiol (EE) / 1 mg norethindrone; 35 mcg EE / 1 mg ethynodiol diacetate; 30/40/30 mcg EE / 0.05/0.075/0.125 mcg levonorgestrel; and 0.35 mg norethindrone.

E. *Status of potential contracting initiative for nasal corticosteroid inhalers* – DoD and VA officials will evaluate the potential for soliciting for a joint VA/DoD closed class contract for a high potency aqueous nasal corticosteroid inhaler after the VA has finished its clinical review of the drug class.

F. *Blanket purchase (BPA) agreements* – The Council wants to be more involved in the process of establishing BPAs in order to ensure that the provisions of a BPA support the Council's strategy for managing a given drug class. The Council also advocates the development of a more clearly defined process for establishing joint VA/DoD BPAs. The Council appointed a subcommittee to work on these issues. Subcommittee members are LTC De Groff, MAJ Filby, and LCDR Briski.

G. *Hepatitis A vaccine contract* – The United States Army Medical Materiel Center Europe (USAMMCE) reports that some facilities are buying Havrix instead of Vaqta, which is the contracted brand of hepatitis A vaccine. USAMMCE did not provide any information about why facilities are purchasing the non-contracted brand. The Council is unaware of any clinical reason for the facilities to use Havrix instead of Vaqta. The Council referred the issue back to DSCP for further investigation.

H. *Low molecular weight heparins* – The Council discussed the suitability of the low molecular weight heparin drug class for a contracting initiative. Additional information, including input from MTF providers, is needed to determine suitability for contracting.

6. **APPLICATIONS FOR DEA NUMBERS** – COL Humburg provided an update on online applications for DEA numbers.

7. **LEUTINIZING HORMONE RELEASING HORMONE (LHRH) AGONISTS** – A BPA makes goserelin available to MTFs at the VA national contract price in exchange for attainment of

an 80% overall share of the MTF prescriptions for LHRH agonists for prostate cancer. At the Nov 00 meeting the Council asked DSCP and the PEC to initiate an education/marketing campaign to ensure that goserelin achieves the market share required by the BPA. CAPT Torkildson reported that the following actions were taken since that meeting:

- Information regarding the Council's decision and the BPA was published in the P&T Executive Council minutes.
- Specialty leaders for Urology in each service were notified of the BPA and informed of the opportunity for cost savings. Information was forwarded to urologists.
- An article was published in the Dec 00 edition of the *PEC Update.*
- Information about the goserelin BPA was provided to the pharmacy and/or urology departments at MTFs with high leuprolide usage.

The Council reviewed MTF prescription data for LHRH agonists, but concluded that it was too early to accurately discern the effect of the BPA on LHRH agonist usage and whether MTFs are on track to achieve the 80% market share for goserelin by 1 Aug 00.

The Council was informed that DSCP recently accepted a BPA from TAP Pharmaceuticals that lowered the price of leuprolide, but still leaves leuprolide with a higher price per dose than goserelin. The Council concluded that the goserelin BPA offers the best value for the MHS. The Council reaffirmed its desire to have goserelin reach an 80% market share by 1 Aug 00 and advised the PEC to continue educational efforts to attain that goal.

8. **DRUG USAGE NOT CAPTURED IN CHCS** – As part of its analysis of LHRH agonist usage, the PEC compared the quantity of LHRH agonists purchased through the prime vendor to the quantity dispensed on outpatient prescriptions. The quantity purchased significantly exceeded the quantity dispensed at 10 MTFs. The discrepancy between the purchase data and the dispensing data is most likely due to the fact that LHRH agonists are dispensed to outpatient clinics through bulk drug orders at some MTFs. Because the agent is administered to the patient in the clinic, the drug usage is not recorded in CHCS. Outpatient drug usage that is not recorded in CHCS is omitted from clinical screening within CHCS and through the Pharmacy Data Transaction Service (PDTS). The ability of the CHCS and PDTS clinical screening processes to improve patient safety is diminished when outpatient drug usage is not recorded in CHCS. This issue was referred to LTC DeGroff, PDTS Functional Program Manager, and COL Heath, chairman of the DoD Pharmacy Board of Directors.

9. **MTF REQUESTS FOR BCF CHANGES**

   A. *Request to remove methylphenidate extended-release (Concerta) from the BCF* – An MTF requested that methylphenidate extended-release (Concerta) be removed from the BCF because:

   - They could find no literature to indicate that Concerta is a superior product to those already available.
   - Concerta is not the only agent that can be dosed prior to the child leaving for school without requiring a noon dose.
   - Having another Schedule II item is always an issue.

According to a recent New Product Bulletin from the American Pharmaceutical Association (APhA), the duration of action is about 12 hours for Concerta, compared to 3 to 6 hours for methylphenidate immediate-release tablets and about 8 hours for the sustained release tablets. To the extent that a longer duration of action is desirable, Concerta might be considered superior to other currently available methylphenidate products.

A PEC analysis of MTF prescriptions for a random sample of patients under the age of 18 who received more than one prescription for sustained-release methylphenidate during FY 00 revealed the following:

- 60% (116/193) of the patients received another medication for ADHD in addition to sustained-release methylphenidate.
- 40% (78/193) of the patients were prescribed a midday dose of either sustained-release methylphenidate or another medication for ADHD.

Although methylphenidate sustained release tablets should theoretically obviate the need for a midday dose, MTF prescription data show that midday doses are frequently prescribed for patients taking methylphenidate sustained release tablets. The Council voted to keep Concerta on the BCF.

B. *Request to add gatifloxacin (Tequin) and remove levofloxacin (Levaquin) from the BCF* – An MTF pharmacy chief suggested that the addition of levofloxacin to the BCF may have been based on (1) an incorrect price for gatifloxacin, and (2) inadequate consideration of *S. pneumoniae* MICs and use in sexually transmitted diseases.

The Council was aware at the Nov 00 meeting that both levofloxacin and gatifloxacin were available for $2.00 per daily dose through BPAs. The Council also considered levofloxacin and gatifloxacin to be very similar in safety, tolerability and efficacy. Levofloxacin accounted for nearly 70% of all fluoroquinolone prescriptions dispensed at MTFs, while gatifloxacin accounted for less than 1% of fluoroquinolone prescriptions.

As requested by the Council, DSCP obtained a revised BPA that makes it easier for MTFs to obtain levofloxacin at the BPA price. The revised BPA offers levofloxacin 250 mg and 500 mg to all MTFs at an upfront price of $2.00 per tablet. Continuation of the BPA price is contingent upon levofloxacin achieving either (1) an 80% aggregate DoD market share within 6 months, or (2) a 50% market share at individual MTFs. Market share will be based on patient days of therapy and will be calculated from USPD prescription data.

The revised BPA achieves the objective of making it easier for MTFs to obtain levofloxacin at the BPA price, since MTFs are no longer responsible for individually monitoring drug usage to meet market share requirements. In addition, use of prescription data eliminates the problem of prime vendor purchases of ciprofloxacin being included in the denominator for calculating levofloxacin market share. However, some of the provisions in the BPA were unacceptable to the Council. The Council asked DSCP to revise the BPA to eliminate the unacceptable provisions.

The Council was also informed that a new incentive price agreement offers gatifloxacin to MTFs at a price of $1.90 per daily dose. The incentive price is contingent on gatifloxacin having a preferred or co-preferred formulary position at an individual MTF.

The Council voted to keep levofloxacin on the BCF. The fluoroquinolone class remains open on the BCF, so MTFs may have other fluoroquinolones on their formulary in addition to levofloxacin.

C. *Request to remove divalproex ER (Depakote ER) from BCF* – An MTF pharmacist asserted that Depakote ER (which is dosed once daily) offers no advantages over Depakote (which is dosed twice daily) because there are no data to prove better compliance.

All oral dosage forms and strengths are generally included for a drug listed on the BCF. The DoD P&T Committee may specifically omit a dosage form or strength from the BCF if it is excessively expensive compared to the other dosage forms/strengths, or if impending availability of a generic equivalent makes it inadvisable to include a given dosage form. Depakote ER is priced essentially the same as Depakote. The Council voted to keep Depakote ER on the BCF.

10. **BASIC CORE FORMULARY REVIEW**

A. *BCF overview and analysis* – The Council reviewed the objective of the BCF and factors that are considered in selecting drugs for the BCF (see Appendix B). The PEC recommended drugs for addition to the BCF based on the following information and analyses:

1) An analysis of USPD data showed that 72.6% of the prescriptions filled at MTF pharmacies in FY 00 were filled with drugs that were on the BCF at the end of FY 00. Prescriptions for most over-the-counter drugs were excluded from the analysis because they generally are not eligible for inclusion on the BCF. The analysis did not characterize second-generation antihistamines, low molecular weight heparins, leukotriene antagonists, and estrogenic vaginal creams as BCF drugs—even though the BCF requires MTFs to have at least one agent from each of those drug classes on the MTF formulary.

2) A frequency distribution of prescriptions filled at MTFs for BCF and non-BCF drugs that was generated from USPD data.

3) A survey of MTFs to determine the MTF formulary status for 98 drugs that are not currently included on the BCF.

4) Input from MTF providers.

5) Drug usage and cost trends from prime vendor and USPD data.

B. *Addition of drugs to the BCF* – The Council was forced to take a conservative approach in adding drugs to the BCF because of the uncertain funding situation for the Defense Health Program in FY 01. The Council added 12 drugs to the BCF, which are listed in Appendix C. [NOTE: A comprehensive list of all BCF and NMOP formulary changes is provided in an appendix to the 8 Feb 01 DoD P&T Committee minutes.]

C. *Drugs not added to the BCF* – The Council considered clinical information and usage data regarding gabapentin, COX-2 inhibitors, and dihydropyridine calcium channel blockers. The Council did not add any of these drugs to the BCF.

D. *Ongoing review* – The PEC is reviewing topical corticosteroids, benzodiazepines, and medications for acne and overactive bladder. Information on these drugs will be presented at the next meeting of the P&T Executive Council.

E. *Status of lancets on the BCF* – A Council member asked why lancets are not included on the BCF. The Council tabled this issue until the next meeting.

11. The meeting adjourned at 1230 hours. The date and location of the next meeting are to be determined.

<signed>
DANIEL D. REMUND
COL, MS, USA
Co-chair

<signed>
TERRANCE EGLAND
CDR, MC, USN
Co-chair

Appendix A: Cost Avoidance in DoD MTFs Due to National Pharmaceutical Contracts, FY 00

Estimated Cost Avoidance in DoD MTFs Due to National Pharmaceutical Contracts, Fiscal Year 2000						
Drug/Drug Class	**Contract Start Date**	**Weighted Average Price/Unit Before Contracted**	**Theoretical FY 00 Cost If Not Contracted**	**FY 00 Actual Cost**	**Cost Avoidance**	**Percent Reduction in Cost**
Statins	1-Oct-99	$0.961874	$94,988,500	$72,672,448	$22,316,052	23.49%
PPIs	1-Oct-99	$1.681407	$97,608,455	$78,179,686	$19,428,769	19.90%
Lisinopril	1-Aug-99	$0.284396	$22,410,939	$12,338,214	$10,072,726	44.95%
Diltiazem	15-Dec-98	$0.631469	$13,077,589	$6,118,739	$6,958,850	53.21%
Ranitidine	16-Nov-98	$0.066602	$3,819,158	$1,956,040	$1,863,118	48.78%
Hepatitis A	18-Sep-99	$16.981597	$8,221,080	$6,546,563	$1,674,517	20.37%
Albuterol	16-Nov-98	$3.297032	$2,882,500	$1,932,971	$949,529	32.94%
Timolol Gel	14-Jan-00	$14.598153	$952,836	$417,571	$535,265	56.18%
Verapamil	20-Aug-99	$0.125912	$2,358,022	$1,804,406	$553,616	23.48%
Cimetidine	16-Nov-98	$0.072763	$833,304	$540,391	$292,913	35.15%
Terazosin	5-Sep-00	$0.459093	$726,193	$539,565	$186,628	25.70%
Captopril	18-Oct-99	$0.036173	$313,233	$171,569	$141,664	45.23%
Nortriptyline	15-Oct-99	$0.049281	$311,276	$227,111	$84,165	27.04%
Gemfibrozil	1-Jan-00	$0.077935	$995,172	$914,650	$80,522	8.09%
Naproxen	3-Jul-00	$0.069829	$752,114	$673,203	$78,911	10.49%
Amoxicillin	7-Aug-99	$0.040549	$560,140	$499,419	$60,721	10.84%
Insulin Syringes	1-May-00	$0.098121	$430,084	$408,406	$21,678	5.04%
Timolol Drops	14-Jan-00	$2.795264	$195,968	$162,419	$33,548	17.12%
Nicotine Patches	1-Jun-00	$2.567746	$518,454	$460,290	$58,163	11.22%
Levobunolol	14-Jan-00	$4.641527	$54,385	$37,522	$16,863	31.01%
Fluocinonide	1-Sep-99	Cream $1.816402 Oint $6.210282 Sol $6.422653	$370,547	$355,800	$14,747	3.98%
Prazosin	1-Nov-99	$0.032916	$132,685	$118,531	$14,153	10.67%
Amantadine	28-Aug-99	$0.063871	$61,008	$53,950	$7,058	11.57%
Naproxen Sodium	3-Jul-00	$0.073176	$47,017	$48,695	($1,678)	-3.57%
Salsalate	15-Mar-00	$0.026462	$79,751	$87,525	($7,774)	-9.75%
Insulin	1-Nov-99	$5.292812	$4,818,894	$5,071,036	($252,142)	-5.23%
Acyclovir	1-Oct-00	$0.121623			NA	NA
Azathioprine	1-Oct-00	$0.477152			NA	NA
Hydroxyurea	1-Oct-00	$0.295324			NA	NA
Pentoxifylline	1-Oct-00	$0.182262			NA	NA
Rifampin	1-Oct-00	$0.566776			NA	NA
Sucralfate	1-Oct-00	$0.198476			NA	NA
Acetaminophen	1-Jan-01				NA	NA
TOTAL FY00			**$257,519,303**	**$192,336,719**	**$65,182,584**	**25.31%**

Explanation of Cost Avoidance Calculations: Cost avoidance equals the difference between (1) the theoretical cost that would have occurred in FY 00 if a contract had not existed, and (2) the actual cost that was incurred in FY 00 for the "market basket" of drugs that pertains to each contract. The theoretical cost that would have occurred in FY 00 if a contract had not existed was estimated by multiplying the weighted average price/unit that existed before the contract took effect by the quantity purchased in FY 00 after the contract was in effect. The "market basket" of drugs includes both the contracted and the non-contracted drugs that pertain to a given contract. For example, the cost avoidance for statins takes into account the expenditures for all six statins, not just the two contracted statins.

Appendix B: Objective of the Basic Core Formulary and Factors Considered in Drug Selection

A. *Objective of the Basic Core Formulary (BCF)*

Ensure uniform availability of cost-effective pharmaceuticals at MTF pharmacies to meet the majority of patients' primary care needs

B. *Selecting drugs for the BCF*

Compare the drug to other agents in the class or other agents that are used for a given disease/condition, based on the following factors:

Safety

Tolerability

Efficacy / Effectiveness

Price / Cost

Other factors, including but not limited to:

- Place in therapy / clinical niche
- Interchangeability of drugs in the class
- Variability in patient response to drugs in the class
- MTF provider opinions/preferences
- Market share trends within the drug class
- Percentage of MTFs that have the drug on formulary
- Potential for inappropriate use
- Patent expirations and impending availability of generic equivalents

Appendix C: Drugs Added to the BCF

Drug	Factors Considered Safety, tolerability, efficacy, price, and other factors (STEPO) relative to other drugs in the same class and/or current BCF items, if any	Percentage of MTFs reporting drug on formulary
Clindamycin 150-mg capsules	S/T/E: Safe and effective for treatment of commonly encountered acute infections. P: Generics available. Capsule prices range from $0.28 to $1.15 (branded 300-mg capsule) O: Class not represented on current BCF. Alternative for skin, soft-tissue, and respiratory tract infections in PCN allergic patients. Needed for treatment of polymicrobial infections where anaerobes are suspected.	Unknown
Loperamide 2-mg capsules	S/T: Safer than diphenoxylate/atropine (e.g., Lomotil). Does not interact with MAO inhibitors or CNS depressants. Does not cause physical dependence. Less drowsiness and sedation compared to diphenoxylate/atropine. E: Efficacy similar to diphenoxylate/atropine. P: DAPA price = $0.046 per capsule, compared to $0.017 per tablet for diphenoxylate/atropine O: Available on a high number of local formularies. A non-scheduled alternative to diphenoxylate/atropine (will not add to administrative burden).	98.7% (155/157)
Chlorhexidine gluconate 0.12% oral rinse (Peridex®, Periogard®, generics) – used for treating gingivitis	S/T: No systemic effects (topical application). Potential cosmetic concerns include staining of the tooth surfaces, restorations, and dorsum of the tongue. Occasional alterations in taste perception. E: No available published literature that treating gingivitis decreases tooth loss. There are conflicting reports on the relationship between periodontal disease and coronary heart disease in men. P: Price ranges from $2.44 to $3.00 for 473 mL bottles O: No similar agents are available on the BCF Satisfies an unique therapeutic niche Dental consultants agreed that this product belongs on the BCF Space limitations may be a concern in smaller MTFs	96.8% (152/157)
Amox/clav (Augmentin) tablets and suspension	S/T/E: Widely used agent proven safe and effective in broad range of infectious processes. P: Already available at nearly all MTFs, so minimal cost impact. O: Class not represented on BCF. Widely used to treat respiratory tract infections and otitis media where penicillinase-producing organism is known or suspected.	Tablets - 96.8% (152/157) Susp – 97.5% (153/157)
Fluconazole oral, 150-mg tablets only	S/T/E: Proven safe and effective for treatment of vaginal candidiasis. P: $6.63 to $6.89 per treatment. OTC cream DAPA price range from $3.35 to $4.42 per 45gm tube. O: No alternatives currently listed on the BCF. As effective as OTC vaginal creams. Offers advantage of single dose therapy and ease of administration.	96.8% (152/157)

Drug	Factors Considered Safety, tolerability, efficacy, price, and other factors (STEPO) relative to other drugs in the same class and/or current BCF items, if any	Percentage of MTFs reporting drug on formulary
Metoclo-pramide oral	S/T: Metoclopramide is well tolerated with CNS side effects of drowsiness, fatigue and lassitude occurring in roughly 10% of patients at normal doses. Extrapyramidal and/or dystonic reactions are rare, occurring in about 0.2% of patients. E: Effective in the treatment of diabetic gastroparesis for which there is no other treatment. P: Price is less than $0.01 per tablet. O: No similar product on the BCF	Metoclopramide 95.5% (150/157)
Mupirocin 1% ointment	ST: Only safety issue would be in patients with renal failure who need to use it on a large open wound area; otherwise mupirocin is not absorbed systemically. No significant tolerability issues. E: Bacitracin nearly 100% failure rate for impetigo. Oral erythromycin now > 50% failure rate due to resistance. Nearly 100% successful treatment of impetigo with mupirocin or cephalexin. Using mupirocin avoids problems related to systemic therapy. Studies were done at Tripler. P: DAPA prices: ointment $22.03 per 22gm tube; cream $16.24 per 15 gm tube, $27.56 per 30 gm tube; nasal ointment $29.57 (box of 10, 1gm tube) O: Nothing similar in this category of therapy on BCF. On the VA formulary with restrictions. Many schools and day care centers will not allow children with impetigo to return until they have been treated.	Mupirocin oint. – 143/157 – 91.1%
Metoprolol 50mg, 100mg oral (Toprol XL is not included in this listing for metoprolol)*	S: Safe when used as directed. Avoid in patients with severe reactive airway disease, concurrent negative inotropic agents, severe or unstable heart failure. T: Well tolerated. β-1 selective agent may minimize β2 blockade related adverse effects (bronchospasm). Selectivity is lost with higher doses. E: Effective in treating HTN, angina, post-MI, selected CHF patients (stable NYHA II and NYHA III). Proven mortality benefit in all these conditions. Usually dosed BID. Can be used QD for HTN in some patients. P: Inexpensive. Metoprolol 50mg generic - $0.02-0.06, Metoprolol 100mg generic - $0.03-0.05, Toprol XL® 50mg - $0.46, Toprol XL® 100mg - $0.92 (Dec 2000 DAPA prices). Toprol XL® 25mg scored tablet – submitted for FDA approval for stable NYHA II-III CHF patients – release date unknown. O: Proven mortality benefit in several indications. Want to encourage use, esp in post-MI patients (decreases mortality and is a HEDIS measure). **Toprol XL® was excluded because there are insufficient clinical advantages to justify the incremental cost compared to immediate release metoprolol.*	Metoprolol – 142/157 – 90.4% Toprol XL – 7/157 – 4.5%

Drug	Factors Considered Safety, tolerability, efficacy, price, and other factors (STEPO) relative to other drugs in the same class and/or current BCF items, if any	Percentage of MTFs reporting drug on formulary
Fluticasone oral inhaler (For complete analysis and clinical information, see Review of Orally Inhaled Corticosteroids, Nov 00 DOD P & T Committee Meeting)	S/T: Fluticasone is equal in safety to other inhaled corticosteroids (ICS) on the market. Adverse reactions appear to be similar to the other available ICS. E: When given in equipotent doses, all the ICS appear to have equal efficacy. Fluticasone, like budesonide, is a high potency ICS that may require fewer puffs per day to achieve control of asthma. P: DAPA prices - 44 mcg MDI $19.88 110 mcg MDI $29.03, 220 mcg MDI $50.65, 50 mcg DPI $21.32, 100 mcg DPI $27.95, 250 mcg DPI $35.98 O: There are no high potency ICS on the BCF. Of the two high potency ICS, fluticasone has a significant share of the market compared to budesonide (39% versus 3.5%). The two high potency ICS are not interchangeable. Budesonide is a dry powder inhaler (DPI); fluticasone is available as both a DPI and a metered dose inhaler (MDI). Given the difference in dosage forms, significant and costly patient education would be required to switch patients currently on fluticasone to budesonide. Budesonide is less desirable than fluticasone because providers report that patients have difficulty in administering the correct dose because of the lack of tactile feedback. Breath actuation with budesonide may be particularly difficult for children.	135/157 (86.0%)
Lactulose syrup	ST: No significant safety issues. Better tolerated than other 2 maintenance therapies recommended for children (mineral oil, magnesium salts). Common side effects (flatulence, belching, abdominal distension, abdominal pain) generally mild. E: Several clinical trials have demonstrated significant increase in stool frequency, weight, volume, and water content compared to placebo. P: DAPA price $3.97/480 ml vs. $17.92 approximate retail price O: Constipation prevalent in pediatric population. Adult therapies not generally used in children	Unknown
Methotrexate oral	ST: Substantial toxicity, low therapeutic index. Not possible to logically compare to other agents. E: No equivalent antineoplastic agent on BCF. No other DMARDs on BCF. Efficacy as antineoplastic agent and immunosuppressive agent clearly demonstrated. P: Generic product available. DAPA price $0.12/tablet; 2.5-10 fold lower than approximate retail price O: Availability of best alternative DMARD (etanercept) greatly limited. Rheumatrex dose packs significantly more expensive than bulk tablets.	80.9% (127/157)

Drug	Factors Considered Safety, tolerability, efficacy, price, and other factors (STEPO) relative to other drugs in the same class and/or current BCF items, if any	Percentage of MTFs reporting drug on formulary
Nitrofurantoin macrocrystals (generic equivalents to Macrodantin) Macrobid is not included*	S/T/E: Specifically for the treatment and suppression of UTI. P: Generics available Price range from $0.07 to $0.87/dose. O: Recommended as one of primary agents in DOD Acute Dysuria or Urgency in Women Guideline. **MacroBid â was excluded because it offers no significant clinical advantage over available generic products.*	Capsules – 72.6% (114/157) Macrocrystals – 79% (124/157) Susp - Unknown